

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **18632**
Registrar's No. **159**

FILED JUN 20 1944

Registration District No. **2043**

Primary Registration District No. **2043**

1. PLACE OF DEATH:

(a) County **MARION COUNTY**
(b) City or town **HANNIBAL**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **ST. ELIZABETH HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 DAYS**
(Specify whether years, months or days)
In this community **2 DAYS**

3. (a) PRINT FULL NAME

IRENE A. FOSTER

3. (b) If veteran,

name war

3. (c) Social Security

No. **NONE**

4. Sex **FEMALE**

5. Color or

race **WHITE**

6. (a) Single, widowed, married,

divorced MARRIED

6. (b) Name of husband or wife

LLOYD FOSTER

6. (c) Age of husband or wife if

alive **47** years

7. Birth date of deceased

FEB 9 1910
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

34 2 27

hr. min.

9. Birthplace

MONROE CITY, MISSOURI
(City, town, or county) (State or foreign country)

10. Usual occupation

HOUSEWIFE

11. Industry or business

MOTHER FATHER

12. Name **JOSEPH RYAN**

13. Birthplace **MONROE CITY MISSOURI**

(City, town, or county)

(State or foreign country)

14. Maiden name **MAE BELLE JONES**

15. Birthplace **MONROE CITY MISSOURI**

(City, town, or county)

(State or foreign country)

16. (a) Informant

LLOYD FOSTER

(b) Address

VANDALIA MISSOURI

17. (a) **BURIAL**

(Burial, cremation, or removal)

(b) Date thereof

5-8-44
(Month) (Day) (Year)

(c) Place: burial or cremation

VANDALIA CEMETARY

18. (a) Signature of funeral director

Wm B Smith

(b) Address

Vandalia Mo.

19. (a) **May 8 1944**

(Date registered local registrar)

(b)

W B Connor
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **AUDRIAN**
(c) City or town **VANDALIA**
(If outside city or town limits, write "RURAL")
(d) Street No. **214 N. MONROE**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **6**

year **1944** hour **5** minute **10 A-M.**

21. I hereby certify that I attended the deceased from

May 3, 1944 to May 5, 1944

that I last saw her alive on **May 5, 1944**
and that death occurred on the date and hour stated above.

Immediate cause of death

Coronary thrombosis

Duration

2 weeks

Due to

Bronchopneumonia

2 months ago

Due to

Bronchial asthma

20 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature **Thos. L. Jumper, M.D.** (M. Doctor)

Address **Vandalia, Mo.**

Date signed **5/8/44**

1146

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

AUG 31 1955

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

working under my personal supervision.

Clyde C. Wilkey, Registered Apprentice No. *3820*

Signed

Clyde C. Wilkey
Licensed Embalmer No. *3820*

P. O. Address *Perry, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.